Colchester Hospital University NHS
NHS Foundation Trust

Trust Offices, Colchester General Hospital
Turner Road
Colchester
Essex
CO4 5JL

Tel: [redacted]
Fax: [redacted]

25 September 2015

Your ref: [redacted]

Mr Thomas R Osborne LL.B
HM Senior Coroner for Bedfordshire and Luton
HM Coroner's Office
The Courthouse
Woburn Street
Ampthill
Bedfordshire
NK45 2HX

Dear Mr Osborne

**Re Inquest touching on the death of Lorraine Joyce Bird**

As an interested person in relation to the above inquest, I have received a copy of your letter to Simon Stevens Chief Executive NHS England dated 10 August 2015 and associated Regulation 28 report in connection with this case. I would like to reassure you that we have taken the appropriate actions detailed in section 5 point (2) of the report, that Lorraine Bird was not given low molecular weight Heparin when attending Colchester General Hospital in August 2014.

The Trust has undertaken as a matter of urgency, the implementation of the Emergency Medicine Network (GEMNet) pathway relating to Thromboprophylaxis for Emergency Department patients with acute lower limb trauma. Approval for commencement was reaffirmed by the Thrombosis Management board on 7 September this year and agreement is being sought from the North East Essex Medicines Management committee at the end of September 2015. An education programme for ED staff has commenced and it is planned to introduce the guidance as soon as funding is agreed.

I trust this provides you reassurance that our Trust has responded appropriately to the concerns raised at the inquest and shared with NHS England.

Yours sincerely

Dr Lucy Moore
Chief Executive

cc [redacted]

**Review of process at CHUFT to introduce Thromboprophylaxis for ED patients with acute lower limb trauma in response to the Coroner's concerns, following a patient death.**

The Emergency Medicine Network (GEMNet), published a summary of the best available evidence to guide the use of thrombo-prophylaxis in adult ambulatory outpatients, who present to the ED following acute limb trauma and requiring temporary immobilisation such as back slab or cast. The first guidance was published in 2012 and a final revision was published in September 2013. It was recognised by the expert witness for the Coroner that although a significant number of ED departments had not introduced this guidance at the time of the incident, it is with great regret that this was also the case at CHUFT.

In response to this a lead consultant was identified and along with colleagues drew up a pathway that would enable local implementation of this guidance. All the relevant parties both within the hospital and community services were involved with development of the pathway. Implementation was delayed due to initial lack of clarity regarding funding of LMWH and blood tests in the community and secondly a delay in printing of a patient passport which had been planned to be supported by an external company that included both information and a pathway of care.

The lead Consultant had a period of prolonged sick leave which caused a further delay and therefore it was not until January 2015 that the passports and associated guidelines were available. The lead consultant then left the trust in February 2015 and due to severe staffing constraints the project was paused.

The trust has undertaken to implement this pathway as a matter of urgency. Approval for commencement has been reaffirmed by the Thrombosis Management board on 7th September this year and agreement is being sought from the North East Essex Medicines Management committee at the end of September 2015. An education programme for ED staff has commenced and it is planned to introduce the guidance as soon as funding is agreed.